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AUTHOR	Cohen, Harris S.; Miike, Lawrence H.
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ABSTRACT

The first part of the thoroughly documented report is described as an effort to clarify and reemphasize the position of the Department of Health, Education, and Welfare with regard to the "two-year moratorium on the enactment of legislation that would establish new categories of health personnel." It also presents a preliminary assessment of the States' response to the recommended moratorium and recommends an extension of the moratorium until the end of 1975 to allow a continuation of efforts already initiated. Part 2 explores recent developments in the licensure of health manpower in the following areas: State studies of licensed health manpower; expanding the role of State licensing boards; licensure and the interstate mobility of health manpower; proficiency and equivalency testing; continuing education and its relationship to quality of care; developments in institutional licensure; and the foreign medical graduate. It is hoped the document will be useful to the States and professions in planning new and innovative directions in credentialing, will stimulate increased interprofessional communication, and will be the first step toward a comprehensive and unified health manpower policy. Ten pages of references, some annotated, conclude the report. (Author/NH)

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DEVELOPMENTS IN HEALTH MANPOWER LICENSURE:

A Follow-up to the 1971 Report on Licensure and Related Health Personnel Credentialing

Harris S. Cohen, Ph.D.

and

Lawrence H. Miike, M.D., J.D.

CE 003 000

June 1973

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FOREWORD

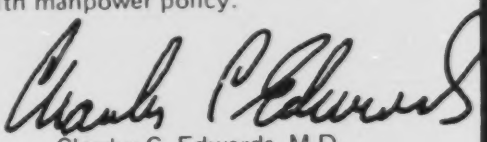
A major recommendation of this Department's 1971 *Report on Licensure and Related Health Personnel Credentialing* called for a two-year moratorium on State legislation that would establish new categories of professional licensure for the health disciplines. This recommendation, originally proposed by certain national organizations, was viewed as an attempt to slow the proliferation of new statutes that would further fragment the existing system of health manpower regulation. While a two-year period was recognized as being too brief for definitive answers, it was hoped that during this time sufficient innovations would have been launched that the present system of health manpower credentialing could be substantially improved.

In the brief period since the 1971 report was submitted to the Congress, and as the initial moratorium period draws to an end, it is clear that more time is needed to assess properly some of the new directions that have been taken by State legislatures, licensing boards, professional organizations, and the educational community with respect to the credentialing of health manpower. In many instances, we have been gratified that the recommended moratorium was instrumental in permitting innovative activities in the States and among the professions. Moreover, having a set framework of time, the moratorium has served to stimulate activities that may eventually lead to solutions as well as to provide an incentive for periodic reassessments of the progress that has taken place.

For these reasons, I am recommending that the moratorium be extended for another two years, i.e., through the end of calendar year 1975. It is my hope that, during this time period, the examination of licensure and manpower credentialing, which continues as a significant Departmental activity, will result in rational manpower policies that will reflect the individual competence and proficiency of health practitioners and the concomitant availability of access to high-quality health care.

The present report constitutes a much-needed follow-up to the 1971 report and demonstrates DHEW's firm commitment to establish an information clearinghouse on professional licensure. It is our expectation that the information on State legislation and professional activities contained in this document will be useful to the

States and professions in planning new and innovative directions in credentialing. I am confident that this report will stimulate more interprofessional communication in the matter of credentialing than exists at present. Hopefully, this may be the first step toward a comprehensive and unified health manpower policy.



Charles C. Edwards, M.D.
Assistant Secretary
for Health

PART ONE

THE MORATORIUM

CHAPTER I

THE MORATORIUM: PRESCRIPTION FOR INACTION OR INNOVATION?

Introduction

In 1971, the Department of Health, Education, and Welfare (DHEW) submitted a report to the Congress, entitled *Report on Licensure and Related Health Personnel Credentialing,* (1) in accordance with the requirements of an amendment to the Public Health Service Act (Public Law 91-519, Sec. 799A). The report identified the major problems associated with licensure and other qualifications for practice or employment of health personnel and included specific recommendations for steps to be taken toward the solution of these problems.

One of the recommendations made in the report called for a "two-year moratorium on the enactment of legislation that would establish new categories of health personnel with statutorily-defined scopes of functions." (2) At the culmination of the two-year period, the accumulated findings and impact of recent licensure developments were to have been reviewed by DHEW to determine whether or not the period of the moratorium should be extended. The moratorium issue has stimulated more interest and speculation than perhaps any other single position taken in the 1971 report, with the possible exception of the recommendation related to institutional licensure. (3) Numerous questions have been raised about the intent and meaning of the moratorium position. This has resulted, in some instances, in a number of interpretations that are neither internally consistent nor in accord with DHEW's original intent in recommending the moratorium.

Given the important policy implications of this concept to the States and health professions and its centrality to the 1971 report, Part One of this follow-up report will address some of the basic questions that have been raised with regard to the moratorium; this report is, therefore, chiefly an effort to clarify and reemphasize the DHEW position. This report will also present a preliminary assessment of the States' response to the recommended moratorium. Part Two contains a number of sections describing significant developments that have taken place since the *1971 Report on Licensure* was submitted to Congress. These two aspects — the moratorium and innovative directions in credentialing — should be viewed as

complementary in that the moratorium is not a proposal for inaction or passivity, but rather for concrete and affirmative action; only in this way can the moratorium be effective.

What are the objectives of the moratorium and why was it recommended:

The 1971 report examined a number of issues underlying personnel licensure in the health field. These included obstacles to career and geographic mobility, the general absence of proficiency measures as alternative avenues in gaining entry to licensed occupations, the emphasis on competence at initial entry rather than at periodic intervals in the practitioner's career, and the general fragmentation of the credentialing process. Developments in the education, utilization, and distribution of health manpower generally have been recognized as occurring at such a quick pace that credentialing by means of State licensure presents obstacles to the utilization of new techniques, educational forms, and personnel categories. Moreover, health services delivery is being organized in a more pronounced "team" structure than in the past, a trend that implies a greater interdependence of the health professions. Hence, greater flexibility in the credentialing process has been urged as a means of adequately responding to the new challenges of manpower training and utilization and the concomitant problems of maldistribution.

A moratorium on statutes that would establish a new licensed occupation not already existing in the State is one approach to counter the growing proliferation of licensed categories in the States. The moratorium was intended to provide the States an opportunity to review their total policy with regard to licensure and the credentialing of health personnel rather than the piecemeal occupation-by-occupation analysis that had become customary in recent years. During this two-year period, the States and health professions would be able to address the challenge of (a) formulating generally acceptable criteria defining those health occupations and tasks that require State regulation, (b) examining the feasibility of alternatives to licensure as a means of ensuring high-quality health care, and (c) assessing the growing number of studies and recommendations in the field of manpower credentialing.

The moratorium, therefore, was aimed toward preventing the proliferation of rigid systems and subsystems of credentialing that did not build upon the alternatives and innovations presently under development. While terms such as "stop-gap" or "holding action"

have been used in connection with the moratorium, the proponents of this position are in agreement that it was not intended as a call for inaction or for simply maintaining the *status quo* of licensed-versus-unlicensed health occupations. Moreover, it opened up the fundamental question of defining the criteria that should be met to justify a State's licensure of a given occupation; as well as the corollary that, even if licensure can be justified, is it the most effective means of quality assurance in the given discipline? (4)

These broad objectives of a licensure moratorium can be achieved by means of an affirmative and dedicated commitment to address the issues cited above and examined, in great detail, in the *1971 Report on Licensure.*

These objectives cannot be achieved by adopting an attitude of passivity or inaction or by hoping that in time the problems will go away. For this reason, DHEW applauds the action taken by certain States and organizations in recently making this commitment to address the issues, to experiment with and demonstrate new approaches in credentialing, and to refrain from enacting new practice acts that follow old models of credentialing.

Did the moratorium concept originate with DHEW?

The DHEW report, while recommending adoption of a moratorium on licensure, did not originate the concept but rather endorsed a position that had previously been taken by two national health organizations: the American Hospital Association (AHA) and the American Medical Association (AMA). (5) Other organizations have also taken this position, including: the American Nurses' Association, the National League for Nursing, and numerous State professional associations. Thus, the moratorium was not a Federal initiative, but rather a cooperative effort on the part of DHEW and a number of professional organizations. The characteristic that distinguished the DHEW position on moratorium, however, was its *two-year* duration. Neither the AHA nor AMA reports specified any time limitation for the moratorium, e.g., the AHA report described the moratorium as a "holding action until long-range solutions are developed."

What occupational categories are included in the moratorium?

It has been suggested that the primary objective of the moratorium was to stem the proliferation of new occupational categories

where the present state-of-the-art with regard to functions and responsibilities is uncertain. Following this line of reasoning, it is argued that the moratorium was directed solely at new categories, but not at older or better defined categories. This reasoning may be employed with much success by proponents of licensure in States that are considering whether or not to license a particular health category; however, it does not reflect the intent of DHEW in urging adoption of a moratorium.

The DHEW licensure report stated with deliberate emphasis that the recommended moratorium "should apply to all unlicensed personnel categories in a given State, although that category is already licensed in other States." (6) The AHA and AMA reports, too, called for a moratorium on licensure of any new or additional occupational categories. (7) This includes, therefore, even the relatively well-defined categories and those that are already licensed in many States. This position reflects the basic intent of the moratorium, which went beyond the concern with newly emerging categories of personnel; the moratorium was geared toward the entire range of complex problems in health personnel credentialing.

Does the moratorium apply to physician assistant legislation?

In answering this question, it is important to distinguish between two basic legislative approaches relating to the physician assistant. One approach accomplishes formal licensure of the physician assistant in ways similar to the other licensed health occupations. This approach entails defining a scope of practice; spelling out the requirements for obtaining a license; and, depending upon whether it is a mandatory or permissive practice act, prohibiting individuals who are not duly licensed from either practicing or using the title of the particular discipline. To date, there has been only one generally-cited instance in which a State legislature established a new licensed category of physician assistants; i.e., the Colorado "child health associate"; however, some States recently have enacted licensure laws for emergency paramedics that are, in essence, physician-assistant practice acts of limited scope. The Colorado Child Health Associate Act has been critically examined in the recent literature; (8) its provisions are almost indistinguishable from the familiar model of health practice acts.

The second and more common legislative approach follows the format of permitting the delegation of certain tasks by the physician to a physician "extender"; i.e., a physician assistant, nurse

practitioner, or other qualified individual. Although the legislative requirements vary from State to State (see Table 1, pp. 12-13), and some States delegate considerable authority to the boards of medical examiners while others do not, the fundamental characteristic of this approach is that it does not establish a new licensed category.

The DHEW report clearly stipulated, as did the AHA and AMA reports, that the moratorium does not preclude amendments to expand existing practice acts. (9) The DHEW report then went on to encourage the States to move in this direction:

> All States are urged to take action that will expand the functional scopes of their health practice acts and that will extend broader delegational authority—both of which will facilitate the assignment of additional tasks to qualified health personnel. (10)

Thus, the moratorium would apply to legislation modeled upon the Colorado Child Health Associate Act but not the more common form of physician assistant legislation. Of course, even the latter form of legislation can produce a *de facto* licensed category. This is especially so in States where the regulations promulgated to execute such enactments contain specific and minute detail as to the eligibility requirements and scope of work that may be legally delegated to the physician assistant. Such close definition, coming at this time, may threaten the viability of this manpower category — as it is very much in a process of development. In recommending that practice acts be expanded to permit delegation of functions to physician assistant personnel, the DHEW report certainly did not call for an "administrative licensure" of this category, as appears to be developing in some States. (11)

When did the moratorium begin?

In part, the confusion surrounding this question is due to the fact that the AHA and AMA reports were released in November and December of 1970, while the DHEW report was submitted to the Congress in July of 1971. It is only with the DHEW model — recommending a "two-year moratorium" — that question of a beginning date has any relevance. DHEW recognized the opportunity to lend greater impetus to the eventual implementation of a moratorium by recommending it in its report to the Congress. The report was submitted to Congress on July 28, 1971, at which time most State legislatures had already adjourned; moreover, it was not

widely distributed until early 1972. The two-year period of moratorium began in January 1972 and terminates at the end of calendar year 1973.

What happens at the end of the two years?

This question almost begs another, more fundamental question: Why did DHEW call for a two-year moratorium when no such limitation was recommended in the AHA and AMA reports? These reasons relate to the discussion above of the moratorium's objectives. The moratorium was not viewed as an end in itself or as a panacea for resolving the complex problems underlying the system of licensure. Instead, it was seen as a means by which concomitant steps and developments might be made possible — that could then point out new directions and alternatives in credentialing.

For this reason, an arbitrary time-limit was placed on the moratorium to emphasize that it was to be assessed in the larger context of current activities and projects relating to licensure and credentialing. Breakthroughs were not expected in this two-year period. The moratorium is but one of a series of action proposals. The purpose and aims of the moratorium will have been achieved to the extent that States and professional organizations begin to address seriously the issues of national standards, career mobility, proficiency and equivalency features, the foreign graduate, continuing education and periodic relicensure, effective disciplinary procedures, and alternatives to individual licensure. If, however, these issues are not addressed and the moratorium is seen as a prescription for inaction, the moratorium will have achieved nothing.

Thus, the two-year period was arbitrarily chosen to tie the moratorium to a set of deliverables. The moratorium is certainly not going to preclude the need for continuing efforts and commitments beyond that period; i.e., the end of 1973. The two-year period should be viewed as an important, but preliminary, effort to resolve the problems in the present credentialing system.

Extension of the moratorium

Inasmuch as the fundamental issues analyzed in the 1971 report remain unresolved, the Department of Health, Education, and Welfare has recently taken the position, as stated in the Foreword to this Report by the Assistant Secretary for Health, recommending that States extend the moratorium on licensure for

another two-year period. This extension will enable the States and professional organizations to continue the efforts that have been initiated in addressing the critical issues that underlie credentialing of health manpower. Some States will have the opportunity to learn from the example of other States that have conducted important demonstrations during the first two-year period. A two-year extension, rather than an unlimited moratorium, is recommended. The moratorium would be reexamined at the end of 1975 — at which time additional action steps would be recommended by DHEW.

What State activity has taken place during the recommended moratorium?

In determining the impact of the moratorium on licensure, an effort has been made by DHEW in two ways to obtain information on how this policy has been implemented in the States.

First, a compilation was made of legislative bills introduced in 1972 that would have established licensure for a health occupation. (Table 2, pp. 14-15.) Each of these bills was reviewed to determine if the intent of the bill was, in fact, to require licensure of a health personnel category that was not previously licensed in the State. In some instances, terms other than "licensure" may have been used in the bill; e.g., "certification" or "registration"; however, if the bill was interpreted as clearly establishing a State licensure requirement, it was so recorded.

Table 2 indicates that as many as 30 of the 37 State legislatures in session in 1972 formally considered legislation to establish a licensure requirement for a total of 14 categories of health manpower. Nine states considered requiring licensure for three or more health occupations that were not previously licensed in these states. As many as 19 States considered licensure bills of a single category, ambulance attendants or drivers — six of these bills were enacted; four, speech pathologists and audiologists; and one each for psychologists, opticians, and physical therapy assistants. Thirteen bills to establish licensure were thus actually enacted into law in 11 States.

Considerable legislative activity in 1972 related to the physician assistant. But inasmuch as this activity was largely concerned with expanding the range of legal delegation to physician assistants rather than the establishment of new practice acts, as described above, it is not included in the present discussion.

Although Table 2 suggests some interesting variation among the States, it is at best only a rough measure of the actual response by the States to the licensure moratorium. The reasons for this are many: first, comparable information is not available on legislative activity in years prior to the recommended moratorium. Consequently, it is not known whether or not the number of new practice acts enacted represents a net decline in such activity as compared to previous years.

Second, the fact that licensure bills were introduced in some States and not in others need not suggest that the legislatively active States did not endorse the moratorium. Inasmuch as the source of these bills is typically an organized professional group with an interest in achieving licensed status by the State, (12) generally, it is not difficult for the group to obtain introduction of such legislation. Thus, the bill may be introduced despite a recognized legislative pronouncement in support of the moratorium. Indeed, this is so even in States that have enacted licensure statutes in 1972. Notwithstanding a State's adoption of the moratorium, the unique political factors in each instance may be responsible for the actual enactment; although the general policy of the State legislature adhered to the concept of the moratorium.

A third point is essentially the converse of the above argument. In some States, licensure bills were not introduced in 1972. This fact does not necessarily mean that the States adopted a moratorium; there simply may not have been any interest or support for such bills.

Another factor that should be considered in assessing the States' response to the moratorium is the question as to whether some States were even aware of the recommended moratorium. Thus, while a number of national and State organizations took very firm positions in support of the moratorium, it is entirely reasonable to expect that some legislatures were completely unaware of the issue and accordingly acted in 1972 just as they would have acted in previous years.

Largely to supplement the information in Table 2 and to resolve some of the problems cited above, a second method was employed to obtain data on the States' response. The DHEW Regional Offices were asked to provide information on the States' response to the moratorium by contacting sources in each State including the

State Comprehensive Health Planning agency, State legislative staff members, and professional associations.

This information, while not complete, complemented the data in Table 2 insofar as it provided a more positive identification of State policy than the legislative activity recorded in Table 2. It was not clear, however, in all cases whether adoption or rejection of the moratorium policy was legislatively determined, such as the currently-pending House resolution in Massachusetts to establish a moratorium, (13) or whether some informal accommodation was made by legislatures and/or certain administrative agencies. Accordingly, this information was provided in some cases and not in others.

Four States — Alaska, Colorado, Kansas and Nevada — were identified, in this process, as having formally adopted a moratorium on licensure. In 1972, no new licensed health occupations were established in these States. Although licensure bills were introduced in Alaska and Kansas (Table 2), none was enacted into law. No such bills were introduced in Colorado, and the Nevada legislature was not in session in 1972. In addition, 30 other States were tentatively identified as informally adopting the moratorium. Of the 11 States enacting licensure laws in 1972 (Table 2), nine States were identified by the DHEW Regional Offices as belonging to the group that informally adopted the moratorium. Only Idaho and Louisiana were considered to have failed to adopt the moratorium. Thus, as noted earlier, even though the general policy of a State legislature reflected adherence to the moratorium, individual attempts at enacting licensing legislation were, at times, successful.

Again, while the information obtained from the DHEW Regional Offices is only a rough measure of the current status of the moratorium, it would appear that about two-thirds of the States have adopted either a formal or informal moratorium on further licensure. Whether or not this will influence the outcome of new licensure bills to be introduced in the forthcoming legislative sessions remains to be seen. Given the increasing concern by the States with the issue of credentialing health manpower, passage of licensure laws may become considerably more difficult to obtain. Already, certain States are embarking in new directions that would update and reform their present licensure systems. The moratorium can provide the States with an important intermediate step in attaining this objective.

In summary, the impact of the moratorium issue may be viewed in two ways. First, by the actual legislative behavior with respect to new licensing — the data that has been compiled is not without deficiencies, but it does identify, for the first time, the degree of legislative activity in this area. A second method of assessing the impact of the moratorium is to examine during this two-year period what positive and innovative measures have been taken by the States — measures that may have profound impact on the future training, utilization, and distribution of health manpower. The effect upon the future is, of course, the ultimate contribution of the moratorium; it is within this context that the moratorium should be recognized as a prescription for innovation rather than inaction.

TABLES

TABLE I - ANALYSIS OF LEGISLATION FOR PHYSICIAN ASSISTANTS IN 33 STATES

TABLE II - BILLS INTRODUCED IN 1972 THAT WOULD HAVE ESTABLISHED LICENSURE FOR A HEALTH OCCUPATION

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TABLE 1 ANALYSIS OF LEGISLATION FOR PHYSICIAN ASSISTANTS IN 33 STATES

STATE	TYPE OF LAW	REGULATORY AGENCY	POWER TO MAKE RULES	APPROVAL OF PA	JOB DESCRIPTION	ACTIVITIES PROHIBITED	CERTIFICATION RENEWAL	PAs PER PHYSICIAN	EDUC PROG APPROVED	APPROVAL OF MD	REPORT TO LEGISLATURE
ALABAMA	Regulatory authority, 1971	Board of medical examiners	Yes	Yes	Yes	Optometry			Yes	Yes	
ALASKA	General delegatory, 1972										
ARIZONA	Regulatory authority, 1972	Board of medical examiners; board of osteopathic examiners	Yes	Yes		Chiropractics, dentistry, optician's services, naturopathy, optometry, pharmacy					
ARKANSAS	General delegatory, 1971					Optometric services					
CALIFORNIA	Regulatory authority, 1970	Board of medical examiners	Yes	Yes	Yes	Dentistry, dental hygiene, optometry	Annual	2	Yes	Yes	1972
COLORADO	General delegatory, 1963										
COLORADO	Regulatory authority, 1969	Board of medical examiners	Yes	Yes		Pharmacy	Annual	1	Yes	Yes	1977
CONNECTICUT	General delegatory, 1971					Dentistry, dental hygiene, optometry					
DELAWARE	Regulatory authority, 1973	Board of medical examiners; Medex board	Yes	Yes	Yes		Annual	2	Yes	Yes	Annual
FLORIDA	Regulatory authority, 1971	Board of medical examiners	Yes	Yes	Yes		Annual	2	Yes	Yes	1973
GEORGIA	Regulatory authority, 1972	Board of medical examiners	Yes	Yes	Yes	Pharmacy		2	Yes	Yes	
HAWAII	Regulatory authority, 1973	Board of medical examiners	Yes	Yes		Optometry			Yes		
IDAHO	Regulatory authority, 1972	Board of medical examiners	Yes	Yes		Pharmacy, dentistry, dental hygiene, optometry			Yes	Yes	
IOWA	Regulatory authority, 1971	Board of medical examiners	Yes	Yes	Yes	Optometry	Annual	2	Yes	Yes	1973
KANSAS	General delegatory, 1964										
MAINE	Regulatory authority, 1973	Board of registration in medicine				Optometry			Yes		
MARYLAND	Regulatory authority, 1972	Board of medical examiners									

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TABLE 1. ANALYSIS OF LEGISLATION FOR PHYSICIAN ASSISTANTS IN 33 STATES. (CONTINUED)

STATE	TYPE OF LAW	REGULATORY AGENCY	POWER TO MAKE RULES	APPROVAL OF PA	JOB DESCRIPTION	ACTIVITIES PROHIBITED	CERTIFICATION RENEWAL	PAs PER PHYSICIAN	EDUCATION PROGRAM APPROVED	APPROVAL OF MD	REPORT TO LEGISLATURE
MICHIGAN	Regulatory authority, 1973	Department of Health	Yes						Yes		Annual
MONTANA	General delegatory, 1970										
NEBRASKA	Regulatory authority, 1973	Board of medical examiners	Yes	Yes	Yes		Annual	2	Yes	Yes	Annual
NEVADA	Regulatory authority, 1973	Board of medical examiners	Yes	Yes		Chiropractics, dentistry, optometry, podiatry, hearing aid specialists		1	Yes	Yes	
NEW HAMPSHIRE	Regulatory authority, 1971	Board of medical examiners	Yes	Yes		Optometry, optician's services					
NEW MEXICO	Regulatory authority, 1973	Board of medical examiners	Yes	Yes		Optometry, podiatry	Annual	2			
NEW YORK	Regulatory authority, 1971	Commissioner of health, commissioner of education	Yes	Yes			Biennial	2	Yes		
NORTH CAROLINA	Regulatory authority, 1971	Board of medical examiners	Yes	Yes			Annual	2	Yes	Yes	
OKLAHOMA	Regulatory authority, 1972	Board of medical examiners	Yes	Yes		Optometry			Yes		
OREGON	Regulatory authority, 1971	Board of medical examiners	Yes	Yes	Yes	Optometry, nursing, dentistry, dental hygiene	Annual	1	Yes	Yes	1973
SOUTH DAKOTA	Regulatory authority, 1973	Board of medical examiners	Yes	Yes	Yes	Chiropractics, dentistry, dental hygiene, optometry, pharmacy, podiatry	Annual		Yes	Yes	1981
UTAH	Regulatory authority, 1971	Medical association							Yes		
VERMONT	Regulatory authority, 1972	Agency of human services	Yes	Yes							1975
VIRGINIA	Regulatory authority, 1973	Board of medical examiners	Yes	Yes	Yes	Pharmacy	Annual	2	Yes	Yes	
WASHINGTON	Regulatory authority, 1971	Board of medical examiners	Yes	Yes	Yes	Optometry, dentistry, dental hygiene, chiropractic services, chiropody	Annual	1	Yes	Yes	
WEST VIRGINIA	Regulatory authority, 1971	Medical licensing board	Yes	Yes	Yes	Pharmacy, optometry	Annual		Yes	Yes	
WYOMING	Regulatory authority, 1973	Board of medical examiners	Yes	Yes	Yes	Optometry		2	Yes	Yes	1975

Source: Dean, W. J. "State Legislation For Physician Assistants: A Review and Analysis," *Health Services Reports*, 88:3 (January 1973), updated to August 1973.

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TABLE 2 BILLS INTRODUCED IN 1972 THAT WOULD HAVE ESTABLISHED LICENSURE FOR A HEALTH OCCUPATION.

	AMBULANCE PERSONNEL	CHIROPRACTOR	DENTAL TECHNICIAN	DIRECTOR, CLINICAL LABORATORY	EEG TECHNOLOGIST	MEDICAL TECHNOLOGIST	NATUROPATH	NURSE ANESTHETIST	OPTICIAN	PHYSICAL THERAPY ASSISTANT	PSYCHOLOGIST	PSYCHOTHERAPIST	RADIOLOGIC TECHNOLOGIST	SPEECH PATHOLOGIST/AUDIOLOGIST
ALASKA									S 401					
ARIZONA	H 2003 *													H 2212
CONNECTICUT	H 140									*				
DELAWARE	H 253													
FLORIDA	S 67													
GEORGIA			S 269					S 697		H 381 *				
IDAHO							S 1495		H 581 *					
ILLINOIS	H 2429								H 767 S 248					
IOWA	S 352								S 489 S 1154		H 163 S 241			
KANSAS				H 1899		H 1899								
KENTUCKY	H 31													H 269 *
LOUISIANA													S 455	H 1361 *
MARYLAND	S 899 *											H 1068	H 968	H 770 *
MASSACHUSETTS	H 5198 H 5894		H 4406							S 418			H 1720	
MICHIGAN				H 4728	H 5401	H 4728			H 5253					S 409

*These bills were enacted into law in 1972.

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TABLE 2. BILLS INTRODUCED IN 1972 THAT WOULD HAVE ESTABLISHED LICENSURE FOR A HEALTH OCCUPATION (Continued)

	AMBULANCE PERSONNEL	CHIROPRACTOR	DENTAL TECHNICIAN	DIRECTOR, CLINICAL LABORATORY	EEG TECHNOLOGIST	MEDICAL TECHNOLOGIST	NATUROPATH	NURSE ANESTHETIST	OPTICIAN	PHYSICAL THERAPY ASSISTANT	PSYCHOLOGIST	PSYCHOTHERAPIST	RADIOLOGIC TECHNOLOGIST	SPEECH PATHOLOGIST/AUDIOLOGIST
MISSISSIPPI	S 2011	H 380		H 634		H 634								
MISSOURI	S 508												H 1294	H 1549
NEW HAMPSHIRE													H 59	
NEW JERSEY														H 1179
NEW YORK						H 9112								H 11733 S 9917
OHIO	H 1220					H 450					S 259			
OKLAHOMA									H 1463					
PENNSYLVANIA	H 2351 S 1435								H 1598		S 367			
RHODE ISLAND	H 5423 S 3453													
SOUTH CAROLINA	H 1423													
TENNESSEE	H 1444												H 1785 S 829 S 1055	
VERMONT											H 320			
VIRGINIA	H 678													S 374
WEST VIRGINIA	H 919													
WISCONSIN	H 367													
No. of States Introducing such Legislation	19	1	2	3	1	5	1	1	7	2	4	1	6	9

PART TWO

RECENT DEVELOPMENTS IN THE LICENSURE OF HEALTH MANPOWER

CHAPTER II

STATE STUDIES OF LICENSED HEALTH MANPOWER

If the moratorium is to be effective, coordinated planning is essential to delineate the steps needed to improve the present licensing structure. Because the primary responsibility for improving the health delivery system resides at the local level, the basic strategies must be developed there and must be modeled upon the health needs and problems peculiar to geographical regions and populations.

At the minimum, each State or group of States with similar needs should, with the aid of professional organizations, begin studies to (a) assess the present relationships of its licensing process to its health-delivery system, (b) identify the problem areas, (c) make specific recommendations for possible solutions, and (d) take steps to ensure that these recommendations are actually put into practice — either administratively under existing laws or by passage of new laws. The last step is the most crucial; numerous studies in the health field documenting salient and pressing problems have resulted in little or no substantive action.

For maximum impact, these study groups must have the necessary influence to ensure that recommendations will be carried out. Inasmuch as assessment of the present licensing process necessarily introduces some new, unproved ideas as models of possible alternatives or supplements, each State may be tempted to defer to others in the initial implementation stages — in the interests of political accommodation. As pointed out above, this wait-and-see attitude may block progress in this area. Alternatives to the present licensing system can only be effectively evaluated by means of actual demonstrations, not by speculation. Moreover, because it is at the local — and not the Federal — level in which most decisions are ultimately made, it would almost appear contradictory for individual States to wait for some "national solution."

Studies conducted in individual States would not be counter to the goal of uniform, national standards of high-quality health care. "Uniformity," as a concept, must not be taken too literally. In fact, such uniformity would probably produce greater inflexibility than exists in the present licensing structure. On the other hand, if there is to be improvement in health services delivery, uniformity in the form of generally accepted minimum standards must be developed.

As stated in one recent report:

> Before a State can put its licensing house in order, a comprehensive survey needs to be conducted of the situation as it presently exists. Detailed information is needed about which occupations are licensed . . . the legislative authority under which various boards operate; about the ways in which they conduct their business, including finances and the costs of conducting programs; about the number of people licensed in various categories; about the ways in which competency is tested, about the pass-fail rates for different segments of the population; and about the ways in which complaints from the public, inspection activities, and disciplinary action are handled. (14)

The moratorium should give the States time to undertake such a comprehensive survey. Each State could then reassess its present licensing system and identify those areas in which the system is adequate and those in which alternative approaches are needed. A comprehensive survey of the present licensing structure does not imply that the structure should be substituted by something else. Given the present state of assessment methodology, licensing with appropriate innovative changes may constitute the best available means of quality assurance in certain disciplines. Research on licensing specifically should not be construed as a determination that it — and not some other credentialing mechanism — is the best assurance of provider competency. Just as it is reasonable that certain manpower categories will be found to require State licensure; others, although presently licensed, may be found not to justify licensure.

The report of the New Jersey Professional and Occupational Licensing Study Commission (15) may provide a useful model for State licensing studies. One important aspect of this study was that State legislators were included among the Commission members. In so doing, three major purposes can be served: (a) the legislators will be exposed to any complexities and inadequacies of the licensing structure; (b) they will be able to assess individual pieces of legislation more objectively; and (c) as legislators, they will have a direct influence in implementing whatever recommendations are made.

Bills introduced to license new professions generally have the organized support of the professions seeking licensure. (16) Because there is usually no comparable group to present other viewpoints, the legislature may acquire an unbalanced impression of the actual need for such status. Commissions that include legislative members

could, therefore, provide greater balance by virtue of building this expertise into the legislature, perhaps, by introducing certain predetermined criteria against which the need to license new categories can be measured. The New Jersey Commission's criteria for licensing groups are:

> Their unregulated practice can clearly harm or endanger the health, safety and welfare of the public and when the potential for harm is easily recognizable and not remote or dependent upon tenuous argument; and,
>
> The public needs, and will benefit by, an assurance of initial and continuing professional and occupational ability; and,
>
> The public is not effectively protected by other means; and,
>
> It can be demonstrated that licensing would be the most appropriate form of regulation. (17)

There is already evidence that the recommendations of the New Jersey study are having a direct impact upon that State's licensing policies given the enactment of one of its major recommendations in the 1971 legislative session, i.e., the addition to each licensing board of one public member and one representative of an agency of State government. (18)

Maine (19) and Illinois (20) have had legislative commissions studying the specific area of health care licensure, and Massachusetts had a resolution pending that would establish a similar commission. (21) The Illinois Act contains the specific charge that the Commission will "recommend possible solutions, and shall, in particular, study methods by which the solution to the above problem may be effected by legislative and administrative changes." (22) This charge focuses on the final, and probably most significant, hurdle in the improvement of health licensing laws and their implementation. While the need for flexibility is recognized, what is not readily apparent is the fact that subsequent interpretation and implementation of statutory laws, in the form of rules and regulations, determine the real impact of legislative action. (23) In recalling that the moratorium is an attempt to avoid rigidly defined functions and requirements for education and training, the corollary encouragement to expand the functional scopes of health practice acts was predicated upon the need for a rational regulatory mechanism that would allow expansion of functions for new categories of personnel. Within the present licensing structure, the professional

boards are the most qualified to perform this dual function. However, it is a narrow line between regulations flexible enough to allow expansion of functions as competency is proved and those regulations whose practical effect is a licensing system. The latter constitutes an "administrative licensure" of the discipline.

By way of illustration, California's physician-assistant statute has been described as a very flexible approach in regulating this category of personnel. (24) However, with the regulations that have been promulgated, the anomalous situation would have existed in which California would have two approved physician-assistant programs (25) but no approved practicing physician assistants in the entire State. (26) In order for a physician assistant to practice in California, three basic requirements must be met: (a) graduation from an approved program of instruction, (b) passing a certification examination administered by the Board of Medical Examiners, and (c) Board approval of both the physician assistant and his supervising physician. (27) Because the Board was awaiting completion of the national certification examination under development by the National Board of Medical Examiners, which will not be ready for use until late 1973, no physician assistant could meet the requirements. While sympathetic to the concerns of the California Board for assurances of competency, flexibility in their use while awaiting national certification tests could have been accomplished. First, accreditation of programs is one measure of competency; and the Board could have provided for utilization by physicians of graduates of approved programs upon the condition that, when the national certification examination became available, certification by examination would be mandatory. Second, the Board could have retained tighter control over graduates, yet allow them employment in California by careful selection of postgraduate physician preceptors who could become extensions of the formal education experience. Instead, by requiring nonexisting certification before employment, graduates of California physician-assistant programs would have been forced to seek out-of-State employment or other alternatives until the national certification examination was completed and adopted by California. In March 1973, the Board of Medical Examiners finally accepted the recommendation of the Advisory Committee on Physician's Assistant and Nurse Practitioner Programs, which allowed for an interim grace-period for the graduate of an approved Physician's Assistant Program until the national certification examination was available.

The California regulations also build in rather rigid educational and functional criteria. Although providing for equivalency and

proficiency testing, the educational requirements are specific and detailed, and the delegated tasks are specified and limited to those enumerated. (28) The delegated tasks are patterned after the AMA recommendations, but the AMA specifically states that the tasks enumerated should not be limitations on the rationale that the "role of the assistant to the primary care physician is not rigidly defined." (29)

In summary, it is encouraging to note that coordinated State surveys, planning, and implementation are going on. The New Jersey Commission is a laudable effort; and the Maine and Illinois Commissions, concerned as they are specifically with health occupations, may serve as models for such coordinated efforts. However, while positive action hopefully will result from these studies, they should not be expected to produce the ultimate solution to the States' health manpower problems. For example, in 1971, the Minnesota legislature asked that State's Comprehensive Health Planning Agency to "undertake the designing of a licensure system which will promote the best use of available health manpower." (30) Not surprisingly, the Council convened was unable to achieve a consensus on the implementation of this charge, but the Report contains an informative compilation of the positions and their justifications of the various professional groups polled.

CHAPTER III

EXPANDING THE ROLE OF STATE LICENSING BOARDS

The DHEW *1971 Report on Licensure* called for strengthening State licensing boards through such steps as increased coordination among boards and other governmental health agencies and diversifying board membership to include representatives of other interests besides those of the professions regulated. (31)

Board Cooperation

In elaborating upon this recommendation, the report noted: "One State has recently passed legislation that calls for the joint promulgation between the medical board and the nursing board of regulations covering nurses in expanded-function settings." (32) This amendment to the Idaho Nurse Practice Act to authorize use of the nurse practitioner gave responsibility for implementation to the Idaho Board of Nursing. (33) It was followed by similar legislative enactments in Arizona (34) and New Hampshire. (35) The Arizona and New Hampshire Acts, however, differ from the Idaho Act in the following ways: First, they do not stipulate that regulations are to be jointly promulgated by the medical and nursing boards, but rather that nurse practitioners may perform such acts as "are recognized by the medical and nursing professions as proper to be performed by a professional nurse under such conditions." (36) Secondly, Arizona vests authority in the Board of Nursing, while New Hampshire's law is silent on this point.

Because the functions of nurse practitioners sometimes fall in a twilight zone between traditional nursing and medical practices — an area, undoubtedly, of some confusion and apprehension, the Idaho law would appear to be the better model. It clearly mandates that medicine and nursing are to decide together on the functions carried out by nurse practitioners. The ambiguity of Arizona's and New Hampshire's laws are of some concern. However, the Arizona Nursing Board has consulted with the Medical, Nursing and Osteopathic Joint Practice Commission, the Board of Pharmacy, and the Attorney General's Office.

Maryland has taken a somewhat different approach from Idaho in amending its Medical Practice Act to permit the delegation of duties to physician assistants. This amendment states that where the delegated duties fall into an area of practice already controlled by a

legally constituted board, regulations will be issued jointly. Where agreement cannot be reached, the Secretary of the Department of Health and Mental Hygiene is to make the final decision. (37) Joint promulgation of regulations is therefore encouraged, and a mechanism is built in to resolve disputes. The joint regulation section, however, clearly applies only to those situations in which health personnel, not licensed by other boards will be delegated tasks by physicians that might fall under the jurisdiction of these other boards. The physician assistant practicing in nursing areas is an obvious example.

The Maryland law, however, contains two points of potential conflict: First, there may be some controversy as to whether certain duties delegated by a physician, in fact, fall within an area of practice already controlled by another board. In considering the changing nature of what constitutes the practices of medicine and nursing (38), this may be the most serious obstacle to effective delegation of duty under the statute. (39) Second, the Secretary of Health may be viewed by the other boards as a less than neutral arbiter, because he is a member of the medical profession.

In June 1971, the Bureau of Health Manpower Education, entered into a collaborative contract with the Washington State Nurses' Association to conduct a study of the Nurse Practice Act in the State of Washington. The basis of this study is the recognition that careful planning and cooperation with other health professions are essential so that a sound foundation is laid for changes that may subsequently be proposed in the Nurse Practice Act.

Among the objectives of the study were (a) to develop a better definition of nursing that reflects the expanding role of the nurse, (b) to clarify the relationship of the professional nurse to others in the health care field, (c) to explore questions of continuing education in relation to renewal of licensure, and (d) to explore the question of the composition of the Board of Licensure. (40) Following this study, the Washington Nurse Practice Act was amended in 1973. (41)

Board Composition

There is growing public sentiment that membership on licensure boards should not be limited to the licensed profession. In this connection, California is often cited as a pioneer with its requirement, since 1961, of a public member on the various boards. (42)

California also increased the requisite public representation on some boards from one to two members. (43) That State's experience with public members sitting on licensing boards is clear indication that there is no danger of disruption of board functioning. On the other hand, the degree to which the addition of public members has resulted in greater public accountability — as opposed to the narrow interests of a particular profession — is open to question. Of course, the very presence of lay members has probably tended to open up some of the secrecy attending board policy-making; but whether this is the sole function of public representation needs to be addressed, for the danger of token accountability lies in a facade of public reassurance, while permitting past practices to continue unabated.

One aspect of this public accountability that needs to be addressed is whether or not the method of placing public members on boards could be improved. Most statutes add public members to the boards, rather than replacing a position previously filled by a professional. Some statutes have also provided for an additional professional member when a public member was to be added. Moreover, because many statutes require professional board members to be selected from a list provided by the organization of professionals being regulated, the public member may have little opportunity to influence the other members. (44)

In 1971, in response to its Licensing Commission report, (45) the New Jersey legislature enacted a statute amending the composition of several of its professional boards. In the health field, these include: medicine, nursing, dentistry, veterinary medicine, optometry, ophthalmic dispensers and technicians, pharmacy, psychology, and X-ray technology. (46) Besides adding one public member to each of the boards, the statute also (a) repealed a section of the law requiring selection of board members from a list provided by the societies, in which only members of the societies could be listed, and made the choice of professional members from these lists discretionary; and (b) added a State government official, who would head a department in the executive branch that would be closely related to the regulated profession. In February 1972, pursuant to this law, the Chancellor of Higher Education was appointed to the Board of Medical Examiners.

In treating the former system of mandatory lists as discretionary, the legislature created opportunity for intraprofessional diversity and, ideally, more objective appraisal — especially in areas of

professional expertise that a lay, public member could not comprehend. It is no secret that many professionals disagree with the views of organized segments of their profession, and such a change in the composition of the boards may result in a better reflection of professional opinion. As Derbyshire has pointed out, "The medical societies are by no means always likely to recommend the most highly qualified people for appointment. All too frequently, they ignore professional and educational attributes, endorsing some faithful political stalwart who has worked his way up in the councils of the medical society. An eminently qualified person who did not choose to belong to the medical society would have no chance of being nominated." (47) Of course, to be effective, this discretionary flexibility will have to be exercised regardless of political constraints.

The New Jersey Licensing Commission's rationale in recommending the appointment of a State official to the board was that more communication between the licensing boards and other State departments was needed — given their mutual concern with such issues as training, education, manpower supply, consumer protection, and health. In addition, a State agency member was viewed as another public spokesman. (48) One study notes that when this legislation was introduced in New Jersey, the addition of a public member met with no opposition, while the addition of a State official was opposed on the grounds that it might enable the Governor to exert undue influence over licensing boards. (49) This study shares the concern that the public member may be only minimally effective and points out that the reasons for the acceptance of the lay member idea by the professions may be owing to the lack of technical competence of lay members to participate in board deliberations, their numerical disadvantage in voting, and their lack of an organized constituency for support. (50) On the other hand, a State official would possess the needed degree of competency, would have access to experts in his own agency, and would possess the power base to oppose board policy that might be against the public interest. (51)

With respect to the possibility of government officials exerting undue influence, politics may play a more influential role in the selection of public, nongovernmental lay members of Boards than in the comparable selection of a governmental representative. Finally, considering the ultimate accountability of government officials to the public, they may be more representative of the "public" than individual, nongovernmental lay members.

There are indications that some legislators are well aware of these problems. In addition to the New Jersey statute, two bills were introduced in the 1972 session of the General Assembly of Pennsylvania, providing for public representatives on State occupational licensing boards and other changes in their composition that would significantly affect board accountability. (52) For example, the State Board of Medical Education and Licensure, presently consisting of seven members, would be expanded to eleven members. The Board currently consists of two government officials and five members who are appointed from the membership or those eligible for membership in the Pennsylvania Medical Society. The proposed provision would have added four public members. The obvious intent of these bills was to provide significant public input in the board and to leave the professions with enough representation to carry out their recommendations in noncontroversial, medical decisions; yet provide a mechanism through which conflict between the lay and professional members would not always be decided in the favor of only one group. These bills may place the deciding votes in government officials. For example, the Board of Optometrical Examiners would have one State official, six optometrists, and five public members. In case of a tie, the State official would have two votes.

Whether or not such power should be vested in government officials and whether or not significant numbers of lay members on boards really will lead to their improvement are obviously debatable. The significance of these proposals, however, lies in the recognition that present board structures are too limited and require changes. The New Jersey statute (53) provides two approaches to change board structure: (a) by allowing for professional representation other than that of the professional associations, intraprofessional differences can be ironed out without sacrificing technical competency; and (b) through membership of a State official, enough of an organized base will be provided to ensure that its representation will not suffer from tokenism. Just as in the relationship between statutes and implementing regulations, the question of whether the New Jersey statute results in board improvement depends on certain political variables such as the Governor's decision to choose professionals other than those recommended by the associations, as well as the individual strengths of the State officials appointed.

Board Responsibilities

Finally, Shimberg has suggested that professional boards become involved in formulating ground rules for licensure problems in their particular areas of expertise and press for needed funding and administrative changes that will make them more effective guardians of the public health. (54) This new role would also include a willingness to give up or modify present functions that may serve as impediments to the objective treatment of providers and patients alike. These additional responsibilities include: (a) establishing criteria governing the licensing of new occupations, (b) assuring competence of licensed practitioners at both the entry and continuation levels of licensing, (c) eliminating requirements not directly related to competency, (d) improving administration of licensing programs to accommodate all who are eligible for licensure, (e) making boards more equitable, especially in their disciplinary functions, where they are often investigator, prosecutor, judge, jury, and probation officer, (f) convincing State officials that their budgets must equal their responsibilities, (g) working actively themselves to increase board public responsibility, (h) working for easier geographical and career mobility, and (i) supporting State policies of nondiscrimination. Certainly, the professional boards are not expected to be the primary movers toward the solutions of the health care delivery problems; but, because their past autonomous roles are now being legitimately questioned, they should be reexamining their relevancy toward the modern health care system in terms of their accountability to the public as public agencies responsible in part for assuring the quality of health practitioners.

CHAPTER IV

LICENSURE AND THE INTERSTATE MOBILITY OF HEALTH MANPOWER

Nonuniform State licensure acts pose direct obstacles to the geographic mobility of health personnel and, thereby, contribute to the serious health personnel maldistribution problem — not only in a geographic sense, but also with respect to certain specialties. Therefore, means to eliminate or modify these obstacles are clearly needed. Increasing adoption of national standards of competency appears to be one of the most promising approaches to this basic problem in providing access to care.

In the development of national standards of competence, enhancing interstate mobility while still providing for sufficient flexibility to meet local needs is a difficult tightrope to walk. Ideally, the quality of health care should be uniform throughout the country, but such unformity of care should consider the unequal distribution of wealth both geographically and individually with respect to the population. Furthermore, a 1969 AMA statement on licensure reciprocity found no primary relationship concerning interstate mobility between the form of reciprocity and the adequacy of a State's physician supply. (55) Yet the present obstacles to geographic mobility pose serious problems to the freedom of choice of the health practitioner as well as to the possible equalization of health services to all populations.

Encouragingly, national standards of competency are rapidly becoming a reality. The DHEW *1971 Report on Licensure* recognized the nursing profession as a leader in the utilization of national standardized examinations and noted that "this approach to uniformity suggests a nation-wide recognition of minimum standards by the profession itself, and would not necessitate any major realignment of the existing State licensing authorities." (56)

Since the 1971 Report, the nursing profession has sought further information on the relationship of licensure to mobility. In June 1972, the Division of Nursing, Bureau of Health Manpower Education, entered into a contract with the National League for Nursing (NLN) to investigate the job-seeking behavior of newly-licensed registered nurses and licensed practical nurses. The project includes learning from these nurses whether or not they are deterred from interstate movement by the requirement of State licensure.

Information from State Boards of Nursing indicates considerable interstate movement of registered nurses. The endorsement system facilitates licensure in a new State once the nurse has secured a license by examination in one State. In 1970, 43,550 nurses received a State license by endorsement.

The question continues to arise, however, regarding the impact of the necessity to secure a license in each State upon poor geographic distribution of nurses by inhibiting their interstate mobility. A "national" license has been suggested as a means of facilitating mobility. Information on this aspect of the NLN study will become available in early 1974. Some indication is expected whether or not the need for a change to a system of "national" licensure is sufficiently impressive to warrant abandonment of the present system of State licensure. (57)

The medical profession is rapidly approaching uniformity of licensure standards — at least in the entry phase of the licensing process. While each State remains in control of its licensing procedures, the adoption of uniform requirements in most States clearly affords greater geographic mobility to physicians. This mobility has been made possible through the development and widespread adoption of two national examinations: the National Board of Medical Examiners and the Federation Licensure Examination (FLEX) of the Federation of State Medical Boards. The National Board certificate is accepted by all States, excepting only Arkansas and Georgia (58); while FLEX is being utilized as the State board examination by a rapidly increasing number of States. Seven States began using FLEX in June 1968; 42 States, in December 1972. By the end of calendar year 1973, 47 States will be using FLEX; and only Delaware, Florida, and Texas will not be using FLEX as their State's licensing examination. (59) Puerto Rico would adopt FLEX, but the cost of translating annually the examination into Spanish is considered prohibitive. Thus, a combination of the National Board examination and FLEX will bring about the possibility of much greater geographic mobility to the medical profession.

Other developments facilitating the mobility of physicians relate to the almost nation-wide adoption of reciprocity and/or endorsement policies in the States and the parallel trend toward some baseline criteria for eligibility. With the adoption in 1971 of endorsement of medical licenses by Florida, only the Virgin Islands among the 53 U.S. jurisdictions has neither reciprocity nor endorsement. (60) Furthermore, there is a discernible trend toward

uniformity of minimal standards among the States for license by endorsement.

As mentioned earlier, National Board certification is accepted by all States except Arkansas and Georgia. Minimal standards for FLEX endorsement are now in effect for Florida, Louisiana, Maryland, and New York, where a FLEX weighted-average score of at least 75 (in obtaining the original license to be endorsed) is required. (61) This requirement is consistent with nearly all of the other States using FLEX, which have a passing grade of 75 for their own candidates. (62) Thus, the National Boards and FLEX provide objective bases for insuring that physicians applying for licensure will have been tested for competence by the same criteria as for those physicians initially licensed by the endorsing State.

While the trend toward adoption of uniform standards is unmistakable and encouraging, certain States' licensure requirements still present limited obstacles to interstate mobility. Arkansas and Georgia do not accept current National Board certification but, in 1973, have begun to use FLEX; yet, paradoxically, Georgia accepts National Board certifications issued prior to October 1953. (63) Delaware, Louisiana, and Texas require licensure in another State before National Board certification is accepted. (64) Basic science boards still exist in 18 jurisdictions; but in 1961, they were required in as many as 24 States. (65) Generally viewed as outliving the original purpose of keeping out cultists, the experience of those States that have recently repealed or liberalized these requirements should provide a model for similar action in other jurisdictions.

Increasing sensitivity to and acceptance of the need for uniform standards of competency provide the opportunity for prospective planning and evaluation of the emerging health professions. In response to the DHEW *1971 Report on Licensure,* the Bureau of Health Manpower Education was delegated the responsibility to conduct a feasibility study of a national certification system for appropriate categories of health personnel. A contract was awarded to the Institute of Public Administration (IPA) in January 1973. The IPA study will pay particular attention to the degree of public accountability presently existing in professional certification and will build upon related studies such as the Study of Accreditation of Selected Health Educational Programs (SASHEP). (66) The feasibility study will exclude medicine, dentistry, and nursing; instead, it will focus on eight health fields in which certification is currently

carried out or contemplated for 17 specific allied health occupations. (67)

Of the 17 occupations to be studied, two — the dietetic technician-assistant and the assistant to the primary care physician — have certification programs under development. The physician assistant certification study, undertaken by the National Board of Medical Examiners in cooperation with the American Medical Association, was announced in June 1972; and a resulting examination will be available by December 1973. Once this examination is established, it would also serve the purpose of providing measurable, uniform standards whereby the qualified physician assistant could have greater interstate mobility and continue to function at his proven level of competence.

In summary, the realization of interstate mobility, qualified only by the States' legitimate concerns over the competency of entering professionals, is fast becoming a reality, primarily, through the development of uniform national examinations. Problems remain with regard to the restrictions to mobility in the established licensed professions and in the resolution of uniform standards for the emerging professions; but these appear surmountable. The trend is clearly toward restrictions based solely upon a concern for competency.

CHAPTER V

PROFICIENCY AND EQUIVALENCY TESTING

The explosion of health technology and the concomitant, ncreasingly integrated nature of current health care have forced the ıealth professions to turn away from the past, individualistic modes of health delivery; but, at the same time, the rapid rate of change ıas introduced inter-professional tensions. Among the sensitive ssues are inquiries concerning the appropriateness of present quali-fications for entry into the various professions in relation to the production and utilization of manpower in the health delivery system.

Early enthusiasm for career mobility emphasized the Horatio Alger qualities of vertical mobility at the expense of the real satisfaction and contribution that might be found in permanent careers within a given level. This implied derogation of the lower steps of the career ladder has added to the fears of some that such a monolithic structure would result in an impersonal job-description categorization at the expense of the human element essential to patient care. (68) Such fears point to the caution that is needed in the rush toward the most efficient utilization of health manpower and serve to remind us that criteria of good health care should include such soft data as provider and recipient satisfaction.

Since publication of the DHEW *1971 Report on Licensure,* much of the progress in the field of proficiency and equivalency testing has been in the conceptualization of how these tests could be used and in the development of the tests themselves. Responsibility for such developments in the allied health field resides at the Federal level in the Bureau of Health Resources Development (BHRD). The Bureau's concern is primarily with proficiency rather than with equivalency examinations due to the potential benefit to a greater number of health workers.

According to a recent Bureau statement:

> Excepting skill examinations, proficiency tests are not difficult to construct and norm once agreement is reached on what should constitute job knowledge requirements. In contrast, academic equivalency examinations must be much more carefully validated and normed if they are to be accepted by a substantial number of colleges and universities. In addition,

course credit examinations must bear a demonstrable relationship to the content of the course at the particular college in which the student seeks credit. A course credit examination in technical health subject matter typically takes two years to develop plus an additional length of time to gain widespread approval and usage. (69)

BHRD identifies the following objectives in the development of proficiency tests:

1. To promote national credentialing systems for the allied health professions that will minimize the difficulties of seeking recognition of qualifications without compromising the standards upon which credentialing is based.

2. To have such credentialing systems largely or wholly self-sustaining, after initial development of standards and administrative procedures.

3. For health occupations for which credentialing is appropriate, to develop acceptable and valid methods of determining that an individual is satisfactorily proficient. For occupations which rely for credentialing on completion of an accredited educational program, one or more alternate methods should be developed to convey an equal degree of recognition of proficiency.

4. To develop these methods, simultaneously if possible, for the established entry-levels of an occupation, except those entry-levels for which vocational training is adequate preparation. Typically, entry-levels suitable for proficiency examinations are (a) the technician or assistant level for which an associate degree program or its equivalent is considered desirable preparation, and (b) the technologist or therapist level for which a baccalaureate degree program is the normal preparation.

5. To promote a set of standards for proficiency in an occupation, applicable to all levels for which proficiency tests are appropriate, so that these standards may serve:

    a. To confer, via certification or registration, recognition by professional associations or by an independent registry for the occupation.

b. As objectives for the professional and/or technical component of educational programs, including continuing education activities.

c. For licensing or registration of individuals by government agencies.

d. To satisfy Federal requirements for the qualification of manpower employed by non-Federal institutions or agencies.

e. As qualifications for Federal employment. (70)

The Bureau of Health Resources Development has begun to implement these objectives in a feasibility study of national certification, as recommended in the *1971 Report on Licensure.*

The Social Security Amendments of 1972 (P.L. 92-603) also contain provisions for proficiency examinations of certain health care personnel designed to satisfy the educational, professional, or other requirements of Title XVIII regulations. (71) Proficiency examinations in physical therapy are already developed and have been administered in 1970 and 1972 for licensed physical therapists who did not meet Medicare standards; a further examination is scheduled for November 1973. A contract is being administered by the Bureau of Quality Assurance (BQA) for development of a similar proficiency examination in practical nursing. In the near future, additional contracts will be awarded by BQA for the credentialing of the medical laboratory technician and technologist, cytotechnologist, psychiatric technician, physical therapy assistant; and for a new examination for physical therapists. Similar proficiency test developments will be conducted in the future in liaison with the Bureau of Health Resources Development as these examinations will have potential applicability beyond the immediate needs of satisfying Medicare requirements.

Since the 1971 DHEW report, separate proficiency and equivalency testing programs have been developed for clinical chemistry, microbiology, hematology, and blood banking. The equivalency examination was included in the November 1972 program of the College Entrance Examination Board. Tennessee plans to use the proficiency examination, already given to more than 3,500 candidates on a pilot basis, to admit former military laboratory specialists to its licensing examination. Recent contracts have been awarded by the Bureau of

Health Resources Development to develop similar proficiency examinations in the fields of occupational therapy, inhalation therapy, and radiologic technology; a contract in the field of medical records is also anticipated. The Bureau of Health Services Research and Evaluation, under a grant to the University of Alabama in Birmingham, is developing a similar examination for the emergency medical technician. Finally, the national certification examination of the assistant to the primary care physician, under development by the National Board of Medical Examiners, will eventually function as a proficiency examination for candidates who do not satisfy certain additional eligibility requirements.

State legislative activity in encouraging proficiency and equivalency test development has been stimulated, for the most part, by the underutilization of military corpsmen returning to civilian life. California provides for qualified corpsmen to become eligible for the LPN and RN licensure examination through substitution criteria. (72) In the 1972 legislative session, Maine for LPNs (73) and New York for X-ray technicians (74) enacted equivalency legislation for returning military corpsmen; Florida provided for proficiency and equivalency testing in its law on certification of emergency medical technicians. (75) Similar activity is anticipated in subsequent State legislative sessions.

The changing attitudes in education toward flexibility in academic requirements are reflected in the increasing acceptance of equivalency training and testing (76) and in the development of core curricula with entry and exit points designed to promote the efficient utilization of manpower. (77) The core curriculum concept has long been implicit in the traditional first two years of medical school, and schools are increasingly allowing for elective time in the latter two clinical years. (78) A program instituted in July 1971 at the University of Miami (Florida) indirectly questions the necessity for a core curriculum in a centralized medical school setting and establishes the possibility of equivalent core curricula. The Miami project involves a special two-year program in which some 20 individuals with doctorates in the biological, physical, and engineering sciences were granted medical degrees in 1973. (79)

Finally, the related work on task analysis has led to some development in new careers in the health field. The Illinois Department of Mental Health now has an operational career ladder that is Statewide. (80) The Institute for Health Research, in Berkeley,

California, conducted under a DHEW grant a systems approach to manpower planning in a community mental health center; plans were included to test both its usefulness and impact on the health delivery system. (81) This project's methodology was based, in part, on a study of health services mobility conducted by the Research Foundation of the City University of New York. (82) The latter study was funded jointly by the Manpower Administration of the Department of Labor (DOL) and the Bureau of Health Resources Development. Similarly, Goldstein and Horowitz have recently completed a two-and-a-half-year DOL study at Cambridge Hospital, Cambridge, Massachusetts, on hiring practices and performance functions of paramedical personnel in hospitals; this work has led to specific recommendations based on their analysis of job structures. (83)

In summary, these activities indicate the extent to which proficiency testing, in particular, and equivalency examinations may contribute to the goal of efficient use of health manpower; while, at the same time, the quality of provider services is maintained or upgraded. The primary emphasis is on proficiency test development due to its direct potential in promoting national credentialing systems for the allied health professions that, in turn, would assure acceptable and valid methods of determining proficiency.

CHAPTER VI

CONTINUING EDUCATION AND ITS RELATIONSHIP TO QUALITY OF CARE

The health professions, long accustomed to the privileges that accompany recognition of their claims to special expertise, have expressed initial resistance to any suggestion that some continued assurance be given of the competence of licensed practitioners. The need for such assurances has received widespread acceptance in recent years; and, in many instances, the professions themselves have initiated important innovations relating to continuing education. But even for those vehemently opposed to State regulations requiring continuing education, there is little debate with the basic premise that points to the need for assuring competence of health practitioners in light of the danger of obsolescence.

Clinical experience, incentives for self-learning that arise from concern for patients and professional pride, and the often-used argument that only the individual practitioner can assess the vagaries of his individual practice should not be dismissed as mere expressions of health professionals' self-interest. In looking behind the terminology used, it can be seen that the concern for quality care is not very different from the concern for legal assurances of professional competency. This is owing to the fact that present indicators of competency do not necessarily reflect high-quality care.

The primary goal of competency standards must be high-quality patient care. To reach this goal at the present time is exceedingly difficult; because quality of care is only now undergoing definition, through such mechanisms as peer review and reassessments of the standard textbook approach to diagnosis and treatment. Researchers in these areas have realized that quality of care is difficult to correlate with past definitions of physician performance. Furthermore, even the method of data collection and communications traditionally used; i.e., the history and physical examination, progress notes, and laboratory charts are often only a hint of the rationale behind diagnosis and treatment regimens. This deficiency has led some researchers to restructure medical record keeping completely by building in both rational data retrieval and continuing education systems through the use of computers. (84)

The growing enthusiasm for continuing education requirements must be tempered by the tenuous state-of-the-art of quality care

assessments. While the basic premise that the conscientious professional should continually keep abreast of advancement of knowledge cannot be faulted; unless clearly related to competency, this premise should not be trumpeted as the solution to assurances of high-quality care. Before the growing enthusiasm for continuing education assumes tidal-wave proportions, its achievements and limitations should be viewed in proper perspective.

It would be appropriate at this point to clarify what is meant by continuing education in the context of this discussion. Inasmuch as the purpose of continuing education is to assure quality of care, any mechanism that leads to appropriate care should be included in its definition. Thus, while the vast majority of continuing education remains remote from care at the individual patient level, those developments directly related to individual practitioner-patient relationships should also be viewed as but one form of this activity. The former type may be regarded as traditional or didactic in method. Course-taking and professional meetings are easily recognized as falling into this category. Further, innovations such as self-assessment tests and simulated clinical situations also fall into the didactic category, because these also occur in a context unrelated to individual patients. On the other hand, review of actual practitioner-patient relationships is at times not so easily recognized as a form of continuing education, for it lacks the formalities associated with more traditional education. Yet, given the nature of the review process with its direct feedback to the professional involved, such forms of continuing education, with appropriate safeguards, probably are better assurances of quality of care.

By focusing on the effects of educational programs rather than on their structure, development of review mechanisms — concerned as they are with the measurement of actual skills — may render present forms of traditional continuing education superfluous, as far as assurances of competency are concerned. Undoubtedly, traditional continuing education would continue, but might be viewed from the perspective of professional incentives for updating knowledge, rather than as a direct assurance of competency on the individual provider level.

What can be expected from traditional or didactic continuing education requirements? At a time when the traditional educational pathways to the professions are being challenged through the development of proficiency and equivalency testing, it might seem odd that for continued competency, the focus is on traditional

educational requirements. This first-glance criticism, however, is not justified in view of the embryonic development of continuing education.

Educational requirements for entry into the professions have been long established and continue to be the major pattern followed by professional personnel, as well as the best assurance of future competency. Proficiency and equivalency testing arose, because some health personnel had reached the same level of functional proficiency as those who had followed traditional educational pathways; but the former group had been barred from professional entry due to adherence to the one-track path. Whether or not proficiency and equivalency testing will remain as alternate paths, or even whether or not they may eventually supplant the formal educational pathway, cannot be determined from their present embryonic state. Of necessity, a system of continuing assurances of competency, being a recent development as opposed to the traditional, initial assurance upon entry into the professions, has had to experiment with both the traditional educational pathway as well as that of a functional or performance orientation. Traditional and didactic educational developments have proliferated, because they are easy to formulate and can be administered on a wide scale.

Even traditional continuing education, however, should be viewed as merely one experimental method of many of assuring quality of patient care. Its experimental nature *per se* mandates that there can be no categorical definition applied at this time. This fact is reflected in the wide range of activities for which credit is given within existing programs. For example, the AMA Physician's Recognition Award covers activities from self-assessment to publication, and it "recognize(s) and give(s) credit for many of the things that most physicians do to keep up to date." (85) The question that may be raised with regard to the great breadth of scope in the AMA program is whether or not it can really accomplish tangible ends. It probably should be noted that the AMA Award was never intended to measure competency, but instead was seen as a stimulus to keep physicians up-to-date by using a reward rather than a disciplinary incentive. As expressed earlier, this is precisely the frame of reference from which traditional continuing education programs should be viewed; i.e., positive incentives to professionals to keep up with current knowledge with the expectation that this somehow will lead to good medical care. The problem with this inadequate reflector of quality of care is that it is easily satisfied by the great majority of physicians in their day-to-day practice and learning; but such

programs do not reach those professionals who do not avail themselves of such opportunities. Therefore, attempts have been made to make such requirements mandatory by tying them in with continued professional society membership and, in a growing number of instances, with relicensing.

In response to the predictable criticism of governmental regulations and the tenuous connection between regulated continuing education and quality of care, it should be reemphasized that such requirements are easily satisfied by the majority of professionals. This approach is a pragmatic attempt to insure that all practicing professionals have the opportunity to base their decisions on the most current information available. Quantifying the minimal level of knowledge required must be left to the individual professions, and "reasonable standards" will obviously allow great leeway in their decisions.

If traditional modalities of continuing education have such amorphous qualities, and if the major rationale is for professional incentive, why require them, especially when the bridge to high-quality patient care is so tenuous? The answer is that it is probably the most practical method available at this time in addressing the quality of care problems on a broad scale. Continuing education, in the traditional forms now employed, is the only type of yardstick practically applicable at this time to a whole professional class. While alternative educational methods such as peer review and outcome measurements may, in the long run, prove to be best; development of these methods is highly imperfect at this time. Continuing education in its present form -- the bulk of which remains traditional — is destined for change; only those forms that are clearly related to continued competence should be maintained. Therefore, statutory requirements for continuing education requirements should allow for maximum flexibility.

What progress has occurred since the DHEW *1971 Report on Licensure* was issued? Courses continue to proliferate. The scope of activity in this area is indicated by the AMA's list of accredited courses for 1972-1973, which includes 2,082 courses offered by 578 institutions in 36 States and the District of Columbia, covering 43 different subject headings. (86) This list, of course, covers only continuing education for physicians and only courses in AMA-accredited institutions. Increasing activity by State medical associations is also reflected in accreditation programs in process in at least 31 States and the District of Columbia. (87) Since the 1971 report,

six State medical associations are or will soon be requiring continuing education, (88) and the DHEW Commission on Medical Malpractice recently recommended that continuing education be mandatory. (89)

Increasing interest in continuing education has resulted in several States now making it a condition for relicensure. (90) Kansas has had an enabling statute since 1969; but implementation depends upon majority recommendation by the Board of Healing Arts, (physicians, osteopaths, chiropractors), and to date no action has been taken, except by the Board of Chiropracty. (91) New Mexico passed a similar bill in 1971, and while the bill stated that the Board of Medical Examiners *may* (not, *shall*) establish mandatory continuing education requirements for physicians, (92) the Board subsequently issued regulations patterned after the AMA requirements. (93) The 1972 Maryland legislative session resulted in a statute identical to New Mexico's, (94) and the Board of Medical Examiners has recently issued its regulations. (95)

In 1972, the Kentucky legislature also passed permissive legislation to allow the State Board of Medical Licensure to require proof of continued competency as a condition to re-licensing. Some of the implications of this law will be discussed below. Nine other bills requiring continuing education of varying intensity for other health professions were passed in 1972. (96) One of these bills, the New Jersey "Continuing Pharmaceutical Education Act," (97) endorses formal continuing education by creating a New Jersey Council on Continuing Pharmaceutical Education and spelling out the subject matter to be covered in the required courses.

In contrast to the New Jersey pharmaceutical law, the Kentucky law on continued competency for physicians takes a more flexible stance on formal continuing education requirements:

> The board may adopt reasonable rules and regulations to effectuate and implement the provisions . . . including but not limited to regulations designed to insure the continuing professional competency of present and future licensees. As an adjunct to the power conferred upon the board by this section, the board may require licensees to submit to interrogation as to the nature and extent of their postgraduate medical education and to require licensees found to be deficient in their efforts to keep abreast of new methods and technology, to obtain additional instruction and training therein. (98)

As of Spring 1973, the Kentucky board has not begun implementation of this provision. (99) This law, by not focusing entirely upon traditional continuing education as the mode of insuring competency, allows for accommodation to more relevant criteria for competency as they develop. While opponents will surely see this as leading to reexamination, such is not the inevitable outcome. Also to be considered are the questionable relevancy of existing examinations to clinical competency, the potential loss of physician manpower that such a requirement might entail, and the rapid development of review mechanisms. What is more important is the flexibility given to the board and the opportunity for the Kentucky medical profession to meet the challenge of developing measurable indicators of competency. Furthermore, the law allows the board to selectively monitor practitioners of questionable competency; therefore, the board is given the mechanism to reach those practitioners most in need of updating their skills and knowledge.

Licensing boards wishing to institute mandatory relicensure requirements probably already have the authority under existing practice acts, because most practice acts leave determination of standards of competency to the licensing boards. California's regulations for physician assistant supervision, for example, mandate continuing education for both the physician assistant and the supervising physician. (100) At the minimum, relicensure would require no major changes in existing practice acts, as the foregoing legislative activity has shown; for as Shindell observes, "It is certainly within the power of the State to require reexamination, just as now it is within its power to require examination for initial licensure." (101)

Other developments may provide further impetus to the establishment of mandatory programs. Furthermore, these emphasize the measurement of skills and are not oriented toward formalized educational requirements. Much of this activity is related to the well-known case of *Darling v. Charleston Community Memorial Hospital,* (102) which legally recognized the increasing institutional nature of health delivery. Hospital licensure in Michigan has been designed on this format since 1968; (103) and the 1972 legislative session produced an amendment that explicitly calls for assurances of competency in hospitals:

> The governing body shall . . . insure that physicians admitted to practice in the hospital are granted hospital privileges consistent with their individual training, experience and other qualifications and insure that physicians admitted to practice in the

hospital are organized into a medical staff in such a manner as to effectively review the professional practices of the hospital for the purposes of reducing morbidity and mortality and for the improvement of the care of patients provided in the institution. (104)

Such requirements can only be fulfilled by building feedback loops to those found in compliance with and those in violation of the standards set by the professional review groups. The methods may vary, but the process of review will all have a common effect; i.e., informing the provider of variation from or conformance to accepted practice. Research and development on methods of medical care review have been in process through DHEW funding of Experimental Medical Care Review Organizations (EMCRO's). (105) Of particular interest to continuing education have been the Hawaii EMCRO, which was structured to educate the physicians reviewed, and the Albemarle County (Virginia) EMCRO, which involved critical reassessment of the traditionally accepted criteria of good care. Because they approach the review process from different points of view, it is inevitable that certain EMCRO's will result in less than viable approaches to measurements of competency. The pressing need for Professional Standards Review Organizations (PSRO's) may force premature application of developing criteria; the caveats expressed previously with regard to traditional continuing education, therefore, apply equally well to the development of these review mechanisms.

In summary, while continuing education programs continue to focus upon the more traditional and didactic modes such as course-taking and professional meetings, the ultimate assessment of quality of care may reside in the development of outcome measurements and other review mechanisms. By focusing on the effects of educational programs rather than on their structure, the latter developments probably are better indicators of what the relevant competency assurance mechanisms of the future will be. In the interim, the traditional types of continuing education programs deserve recognition as minimal assurances of competency and indicators that the professions are willing to provide those assurances to the public.

CHAPTER VII

DEVELOPMENTS IN INSTITUTIONAL LICENSURE

Although there is growing acceptance that the present, fragmented licensing system is rapidly becoming inadequate for the increasingly complex delivery of health care, there is no consensus as to how it should be restructured or replaced. Institutional licensure is posited by some health services researchers as being the most appropriate regulatory mechanism, due to its reflection of the integrated nature of the majority of health services delivery today. Others see its introduction as producing more problems than it purports to resolve. (106)

In attempting to establish a coherent, interrelated health delivery system, there must be meaningful working relationships among the individual professions. Yet, given the traditional hierarchy of professions long extant in health services delivery and the struggle by numerous professional groups to attain status and recognition through State licensure, a certain degree of interprofessional conflict is inevitable.

Institutional licensure may generate further conflict, because it not only purports to deny to the emerging professions the status of individual licensure, but also threatens presently licensed categories, which are fearful of losing their "professional identity." Additionally, those professions primarily involved in the day-to-day care of individual patient needs see the institutionalization of licensing as primarily geared toward administrative convenience. Such fears are only enhanced by the usual hospital model proposed, for it is generally assumed that the hospital administrator, usually a clinical layman, would wield ultimate authority in decisions affecting clinical practice. Such fears are understandable; and, when coupled with the realization that this simplified model may introduce more problems than presently exists with individual licensure, resistance to experimentation in this area is not surprising.

Institutional licensure, however, is not a developed concept; it is merely a convenient descriptive term applied to the need for a unified health delivery system similar to the use of eponyms in describing new medical syndromes. Anyone familiar with the complexities of health care delivery immediately recognizes that implementation of any unified scheme of licensure is difficult at this time. This fact is chiefly due to the expansion of medical

knowledge and delivery, which has resulted in expanded roles for established professions and the emergence of new disciplines. Institutional licensure does not prescribe the voluntary or involuntary abdication of responsibility by some, or the domination by one group over others — especially in areas where the expertise of the various groups is unique. It would be a mistake to view institutional licensure as the setting for a power struggle among professional groups, especially because the basic rationale for the concept rests on the need for professional cooperation.

Institutional licensure is still a developing experimental model; it does not threaten professional functions based on rational criteria; it may not offer a better solution than continued individual licensing for certain professions; it necessarily involves interprofessional cooperation to define its basic parameters and determine the extent of its feasibility; and it may provide a better framework for public accountability. Nevertheless, it is time to test the concept. Accordingly, this is not the time to evaluate its worth, for there are no present criteria for doing so.

Health care delivery today may be viewed as a form of institutional licensure. It is common knowledge that within each licensed profession, actual scopes of duties are restricted by prescribed competency limits. This has approached "voluntary licensing" through such modalities as specialty board certification, additional educational requirements for certain functions within professions, staff regulations in hospitals, and even the specialist referral system used by most practicing private physicians. Even in the allied health fields, such restriction by voluntary specialization has taken place. While this *de facto* institutional licensure is common knowledge, there has been no attempt to systematically document its extent and compare it to the theoretical scope of practice that individual licensing purports to regulate. This may be an important starting point for the investigation of institutional licensure. Related studies may already contain the data necessary for such an analysis. The work on task analysis by Goldstein and Horowitz, (107) and Gilpatric, (108) may provide the basis for examining the assumption of *de facto* institutional licensure for the types of institutions and personnel studied. Furthermore, demonstration projects on institutional licensure would, of necessity, document the extent of the *de facto* situation.

Documentation of such practices does not necessarily mean that formalizing the structure will improve the system. Before that

is done, such change would have to be justified by showing that it is of greater value than accommodating the present licensing system to such practices; moreover, it would have to be demonstrated that it would function more effectively than the *de facto* situation.

The first study addressed directly to institutional licensure was begun in July 1972 at Rush-Presbyterian-St. Luke's Medical Center in Chicago, Illinois. The study is being supported by the Bureau of Health Services Research and Evaluation, Health Resources Administration. This study focuses on health personnel who function in dependent roles, primarily those not presently licensed. Representatives of several professional organizations are integrally involved in the study. The Hospital Educational and Research Foundation of Pennsylvania has recently been awarded a similar grant. Additional interest in this area has been expressed in the proposed revision of the Health Professions Education Master Plan of the New Jersey Department of Higher Education, the Massachusetts *Report of the Health Manpower Subcommittee of the Governor's Advisory Council to the Office of Comprehensive Health Planning* (April 1972), the report of the *Wisconsin Governor's Health Planning and Policy Task Force* (November 1972), and the report of the DHEW *Secretary's Commission on Medical Malpractice*

Finally, related developments in statutory laws may provide the greatest impetus toward a unified licensing structure. As discussed above, the *Darling* decision (109) has already led to legislative action reflected in the Michigan hospital licensing act. (110) Whether such developments result in quality monitoring through additional safeguards built into the present licensing structure or through a new credentialing system such as proposed by institutional licensure, the result should clearly be one more closely tied to the actual functions of any individual health care provider.

CHAPTER VIII

THE FOREIGN MEDICAL GRADUATE

A significant factor in the evolution of medical delivery in the United States has been the foreign medical graduate (FMG). Of necessity, this report can only touch upon certain aspects of the licensing problems encountered by the FMG seeking licensure and mobility, the licensing agencies and professional organizations concerned with their competency, and the often pragmatic needs of the States to tradeoff their manpower requirements against the desire to maintain uniform measurements of competency. The problems of the physician foreign graduate are emphasized here and in other independent reports due to the physician's significance on the health care team, the large number of foreign trained physicians already in the country, and the increasing number entering the U.S. in recent years. FMG's entering the U.S. now equal the total number of physicians graduating from domestic medical schools in any year; they comprise about a fifth of the active physicians and a third of hospital interns and residents. (111) There may be as many as 10,000 FMG's now in the U.S. who have failed to pass the examination of the Educational Council for Foreign Medical Graduates (ECFMG) and/or State licensure examinations. (112) Many of these FMG's are believed to be employed in the practice of medicine in state mental and chronic disease hospitals under temporary permits, limited licenses, or special institutional licensing arrangements.

Resolution of the problems of foreign-trained professionals cannot be accomplished without the combined, concerted actions of health organizations and government agencies. These concerns have not gone unappreciated. Margulies and Bloch (113) have indicated the problems associated with this extraterritorial supply of manpower. The ongoing work of Dublin (114), Stevens and Vermeulen (115), and the Commission on Foreign Medical Graduates, established in response to a recommendation in the *Report of the National Advisory Commission on Health Manpower,* (116) hopefully will provide information to form the basis for responsible policy development in this area. Studies such as these are particularly needed in the area of foreign health manpower, for the problems associated with this source of health manpower have developed in a relative void of reliable data.

Other health occupations have also experienced this dearth of studies for reliable data upon which to base sound policy

development. For example, in collecting reliable data, nursing experiences many of the same problems as medicine. Data is available only on the number of foreign nurses who successfully obtain a license. However, the Council on State Boards for Nursing is aware that the number of foreign nurse graduates applying for licensure far exceeds the number who ultimately secure license. Inasmuch as most of these unlicensed nurses are probably employed at some level of nursing, it is possible that these nurses suffer some exploitation by being required to carry professional nurse responsibilities while being employed in a lower-paying position. While foreign nurse graduates have contributed to the total supply of nurse manpower, there is no data on their eventual location in this nation; although there is some indication that they tend to cluster in areas better served than the rural or other underserved areas.

Questions of the types delineated above have led the Division of Nursing, Bureau of Health Resources Development, to contract with the American Nurses' Association (ANA) to conduct a nationwide survey on the experience of foreign nurse graduates in securing a State license to practice. (117) The survey will seek information on: (a) the number and characteristics of foreign nurse graduates who apply for licensure; (b) the number and characteristics of foreign nurse graduates who fail to obtain licensure and their educational deficiencies; (c) the availability and effectiveness of remedial courses and their utilization by foreign nurse graduates; and (d) the number of foreign nurse graduates "certified" for employment temporarily, pending licensure.

The contract also requires an analysis and summary of the State Nurse Practice Acts and State Boards of Nursing rules and regulations as they relate to licensure and temporary employment permits for foreign nurse graduates as well as an analysis and summary of U.S. immigration laws and regulations applicable to the immigration of foreign nurse graduates.

Results of the ANA survey are expected in early 1974. The conclusions should assist in developing recommendations and programs to enable foreign nurse graduates already in this country to secure a license appropriate to their preparation. The information will also assist in determining whether or not changes are needed in immigration laws and regulations that deal with nurses. Finally, because many of the questions being asked in this survey are appropriate for other categories of foreign health personnel, this survey may have value far beyond the specific area of the foreign nurse graduate.

In returning specifically to the problems of the FMG, the international political and ethical questions relating to the utilization of FMG's in the United States are recognized; and while this Nation has not prohibited their continued entry, the problem of their proper integration into our health delivery system will not disappear. How, then, are those directly concerned with FMG's and the licensing systems attempting to solve the problem? Three issues — the licensure and mobility of FMG's, agency and organizational concern over competency, and pragmatic manpower needs of individual States show early signs of potential resolution and accommodation.

The FMG continues to be treated differently than U.S. medical graduates (USMG's) in the qualifying and licensing schemes of the States; but there has been an increasing uniformity, at least in examination requirements, with a concomitant reduction of some of the requirements unrelated to competency, such as State citizenship. As documented earlier, uniformity is being achieved by the adoption of FLEX by the States. Because FMG's are not eligible to take the National Boards, the individual State examinations and, thus, FLEX are increasingly becoming FMG exams: to illustrate, FMG's now total about 75 percent of the candidates for State licensing examinations utilizing FLEX. (118) The adoption of FLEX has made it possible to standardize passing grades and, thus, open the door to greater geographic mobility of FMG's. For example, Arizona has amended its medical practice act to allow easier endorsement of FMG's. Under two conditions, the written examination is waived: first, if applicants are licensed in another State by written examination and are board eligible in an approved medical specialty; or, second, if they are licensed by another State as a result of passing the FLEX examination. (119) Arizona, which uses FLEX, can now also use it as an indicator of the reliability of other States' licensing examinations.

Unquestionably, the failure rate remains high on FLEX; but this is to be expected, if competency levels are to be maintained. For all FMG's taking the complete FLEX from June 1968 to December 1972, 50.4 percent failed, as compared to a 14.8 percent failure-rate for USMG's. (120) While the FMG failure-rate remains high, FLEX now provides a basis for comparison of candidate performance among States and provides a standard definition of a failing grade.

In seeking a solution to physician storages and maldistribution, there have been a number of interesting reactions by some States,

which at times have led to a lowering of standards. Indiana showed an increase in the number of licenses issued in 1971, reflecting a new law that permitted FMG's to take the State examination without prior U.S. hospital experience. (121) If the applicant passes, a limited two-year license under a preceptor physician is given, after which time the applicant is fully licensed. West Virginia, where most of the candidates for the State examination are FMG's, had to lower its passing grade from 75 to 73.2, because a majority of the applicants were failing. (122).

The recent Arizona law, mentioned above, also attempts such an accommodation. Under this law, a three-to five-year license may be issued to an FMG lacking one or more of the following: (a) ECFMG certification or its equivalent, (b) the required approved internship or postgraduate training, (c) U.S. citizenship, (d) a weighted-grade average of not less than 70 percent on a failed written examination. The Board has authority to determine annually the need for limited licenses and may grant them for practice in designated geographical areas, presumably with the observation and evaluation considered necessary. If, during this time, the FMG obtains U.S. citizenship and passes the State examination with a grade average of 75 percent or more, he will be granted a regular license on the expiration of his limited one.

Scaling down licensure requirements to meet physician manpower needs is not a new development. Many States have special licenses or permits for medical practice, predominantly in State mental institutions. Such utilization of physicians has often been condemned as a form of cheap labor, but due to FMG's willingness to accept these conditions and qualified physicians' lack of enthusiasm to serve in these areas, these practices have continued.

In the process of obtaining a regular license, Arizona's law permits not only the waiver of both ECFMG certification and clinical training, but also permits the substitution of other test requirements in lieu of ECFMG certification; Kentucky has also done so. (123) In New Jersey, a similar attempt to eliminate the requirements of prior graduate clinical training and ECFMG certification as prerequisites to internship and residency programs was introduced in the 1972 legislative session. (124) New Jersey is known to have difficulty filling house-staff positions, and the 1971 AMA statistics show an FMG-USMG ratio of 295/383 interns and 718/1,027 residents in that State. (125) Compounding the problem is the need of New Jersey hospitals for adequate numbers of house staff, on the

one hand, and the issue of the educational quality of house-staff positions that are mainly filled by FMG's, on the other hand. USMG's are not attracted to these programs due to their service orientation and lack of any real educational content. (126) Therefore, New Jersey is a State particularly subject to two pressures: (a) the manpower needs of its hospitals, and (b) pressure from FMG's, including those of U.S. citizenship, to change its standards to allow for easier entrance into the State's health care system.

The AMA has expressed concern over these legislative attempts to circumvent the clinical training requirements and ECFMG certification by citing the extensive clinical training USMG's obtain prior to internship, the competency screening function of the ECFMG test, and the great variations of foreign medical school quality. In recognizing the increasing phenomenon of the American FMG, due to limited U.S. medical school opportunities, two alternative pathways to a U.S. medical program have been developed for those FMG's who would have been otherwise qualified for admission at home. Through the "Fifth Pathway," sponsored by the American Medical Association, the qualifying student is sponsored by an approved U.S. medical school for a year of supervised clinical experience and then moves on to internship training. The Coordinated Transfer Application System (COTRANS), established by the Association of American Medical Colleges in January 1970, provides for the transfer of U.S. citizens studying medicine abroad to American medical schools. (127)

Inasmuch as the great majority of FMG's are not Americans, an alternative must be found for upgrading their training and competency. Methods such as those of Arizona and West Virginia are open to criticism, because they lower the standards. A more direct approach — one that cannot be criticized as lowering standards — is to educate those FMG's whose only barrier to practice is failure to pass the licensing examination. Failure on licensing examinations does not always reflect an inadequate foreign medical training. Other factors such as language and cultural barriers, lack of experience in objective test-taking, and poor U.S. postgraduate training also contribute to the failure rate. Methods that could correct these deficiencies may increase the supply of physicians without sacrificing quality.

In 1971 alone, 3,625 of 10,373 FMG's who took State licensing examinations failed. (128) If a reasonable percentage of such persons could have their education upgraded, larger numbers of

practicing physicians could be made available. Courses aimed at helping FMG's pass the ECFMG or State licensing examinations are not new; for example, the University of Miami School of Medicine has given such courses since 1961. A somewhat different approach has been taken in Puerto Rico under a contract from the Bureau of Health Services Research and Evaluation. (129) This program focuses on those FMG's who had failed the medical licensing examinations in Puerto Rico and attempts to identify the characteristics of this particular class of FMG's in order to tutor them in their deficient areas of knowledge. Such a program should begin to provide the basic information needed in assessing the specific areas in which the education of FMG's is deficient.

Finally, it is important to note that most of the discussion of State licensing requirements for FMG's has focused on the consideration of the FMG as a potential practicing physician. Considering the tremendous variations of foreign medical education, it may well be a quixotic goal to expect entry of most or all FMG's directly into physician functions. Before decisions can be made about the role of the FMG in the domestic health scene, reliable data upon which to base those decisions must be made available. How many unlicensed FMG's are now permanent residents of the U.S.? How many have found employment in allied health roles? Are they functioning adequately in these roles; What is the actual educational content of hospital intern and residency training programs that are predominantly filled by FMG's? As questions of this nature are answered, policies on such matters as the introduction of some FMG's into related health occupations may be addressed. In light of the expansion of delegated tasks reflected by the physician assistant and nurse practitioner programs, such a solution for the employment of at least some FMG's may be more rational than the present all-or-nothing choice facing FMG's seeking physician licensure. Moreover, a survey of FMG's in allied health fields may indicate that such employment is wide-spread. Hence, a nationally developed policy might assure more appropriate regulation than what presently exists in a *de facto* situation.

The introduction of the FMG into related health occupations, however, is certain to produce problems of its own. Two such problems are (a) the regulation of the FMG in these auxiliary roles, and (b) the inevitable redefinition of the functions of U.S. postgraduate training in the education of FMG's. The employment of FMG's on a limited-license basis such as those presently in State mental health and chronic disease hospitals has led to their restricted practice of

medicine in these settings. A similar result may occur if the non-licensed FMG is designated as a physician extender, and inadequate supervision is provided. First, the temptation would be to exempt him from qualifying examinations for these dependent roles. Although flexibility in eligibility requirements would be appropriate, proof of competency for a particular health profession should be required because the quality of services provided must be maintained. Second, the pressures to delegate more authority to the FMG physician extender would be great because his role would be constricted, rather than the expanded role of the usual physician extender.

As far as the educational purposes of FMG postgraduate training in this country are concerned, introduction of the FMG into related health occupations would cause many institutions to reassess their physician postgraduate training programs. Furthermore, the foreign policy implications of such a step can only be indicated here. This reorientation of the FMG's role in the U.S. health system would question directly not only the basic quality of every foreign country's medical education system, but would also require these countries to reassess their reasons for allowing their medical graduates to come to the U.S. for further training.

Despite the reservations cited above, the introduction of some FMG's into related health occupations may be feasible. Methods could be devised that would place FMG's of appropriate qualifications into corresponding roles. For example, in a recent "Report and Recommendations Regarding the Use of Unlicensed Physicians in the Provision of Ambulatory Health Care in Private, Non-Hospital Clinics," the Comprehensive Health Planning Council of South Florida recommended that FMG credentials be accepted as the equivalent of approved training programs for physician assistants. (130) While the quality of foreign medical education may suffer by comparison with U.S. standards, it is nonetheless of considerable value. If the FMG is here to stay, then he should be integrated into the total health delivery team and not be forced into a mold that he may not fit.

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(2) *Ibid.*, pp. 73-74. (Recommendation No. 1.)

(3) *Ibid.*, p. 77. (Recommendation No. 7.)

(4) In this connection, the criteria for licensure recommended in a recent New Jersey report on licensing (the New Jersey Bateman Commission) are of great relevance. These are cited in the next chapter. See note 15.

(5) See American Hospital Association, *Statement on Licensure of Health Care Personnel,* approved by AHA, November 18, 1970 (Chicago, 1971), pp. 4-5; and American Medical Association, *Licensure of Health Occupations,* adopted by House of Delegates, December 1970 (Chicago, 1970), p. 8. A resolution urging adoption of a moratorium was also made by the National Advisory Allied Health Professions Council, on February 16, 1970.

(6) DHEW, *1971 Report on Licensure,* p. 73.

(7) *Supra,* note 5.

(8) See Silver, H. K., "New Allied Health Professionals: Implications of the Colorado Child Health Associate Law, " *New England Journal of Medicine,* 284:304 (February 11, 1971); and Curran, W. J., "New Paramedical Personnel — to License or Not to License?" *New England Journal of Medicine,* 282:1085 (May 7, 1970).

(9) DHEW, *1971 Report on Licensure,* p. 74.

(10) *Ibid.* (Recommendation No. 2.)

(11) This is discussed in greater detail in the next chapter.

(12) See Akers, R. L., "The Professional Association and the Legal Regulation of Practice," *Law and Society Review,* 2:463 (May 1968); and Cohen, H. S., "Professional Licensure, Organizational Behavior, and the Public Interest," *Milbank Memorial Fund Quarterly: Health and Society,* 51:73 (Winter 1973).

(13) See Mass. House Resolution No. 3155, "Providing for an investigation and study by a special commission relative to establishing a two-year moratorium on any additional licensure of health occupations" (introduced 1973).

(14) Shimberg, B., Esser, B. F., Kruger, D. H., *Occupational Licensing: Practices and Policies,* (Washington: Public Affairs Press, 1972), p. 221.

(15) *Regulating Professions and Occupations,* Report of the New Jersey Professional and Occupational Licensing Study Commission, January 1971. (Hereafter, *New Jersey Bateman Commission.*.)

(16) *Supra,* note 12.

(17) *New Jersey Bateman Commission,* p. 6.

(18) N. J. Stat. ch. 60, sec. 5 (1971).

(19) Subcommittee on Occupational Licensing of the Maine Legislative Research Committee, Joint Resolution passed by Maine Legislature, 1972.

(20) Illinois Health Care Licensure Commission, Ill. Public Act 77-1511, September 10, 1971.

(21) Mass. Senate Resolution No. 897 (introduced 1972). A similar resolution was introduced in 1973 (House Resolution No. 3155, *supra,* note 13).

(22) *Supra,* note 20.

(23) Cohen, *op. cit.* pp. 79-80. See Shimberg, *et al, op. cit.,* pp. 54-55, describing the initial opposition of the California Nurses' Association to the 1969 statute providing for medical corpsmen eligibility to take the R.N. examination.

(24) See Illinois Health Care Licensure Commission, Minutes of Meeting, April 28, 1972, p. 3, referring to Cal. Bus. and Prof. Code Art. 15, ch. 5 (West supp. 1970).

(25) As of mid-1973, the approved physician assistant programs are located at Drew/UCLA and Stanford University.

(26) Telephone conversation with D. S. Rios, Assistant Secretary of the Physician's Assistant Advisory Committee of the California Board of Medical Examiners, December 5, 1972.

(27) Cal. Adm. Code ch. 13, art. 15, sec. 1379.20 and sec. 1379.40 (December 1972).

(28) *Ibid.*, sections 1379.23 to 1379.25.

(29) AMA Council on Medical Education, *Educational Programs for the Physician's Assistant* (Chicago, 1972), p. 5.

(30) Minnesota CHP, "Credentialing Health Personnel in Minnesota, A Report to the Legislature," (November 15, 1972).

(31) DHEW, *1971 Report on Licensure,* pp. 75-76.

(32) *Ibid.*, p. 76.

(33) Idaho Code sec. 54-1413, as amended (1971). See State of Idaho Administrative Procedures Act. *Minimum Standards, Rules, and Regulations for the Expanding Role of the Registered Professional Nurse,* jointly promulgated by the Idaho State Board of Nursing and the Idaho State Board of Medicine, June 1972.

(34) Ariz. Rev. Stat. sec. 32-1601, as amended (1972).

(35) N. H. Rev. Stat. Ann. 326-A:2, as amended (1972).

(36) Arizona and New Hampshire laws, *supra,* notes 34 and 35.

(37) Md. House Bill No. 468 (enacted 1972).

(38) "In this period of rapid transition, the identical procedure performed on a patient may be the practice of medicine when carried out by a physician or the practice of professional nursing when carried out by a nurse, "U.S. Department of Health, Education, and Welfare, *Extending the Scope of Nursing Practice* (Washington: U.S. Government Printing Office, 1972), p. 12.

(39) While the statute provides that the Secretary will make the final decision on disagreement over the regulations to be issued, it is silent on his role in the determination whether delegated duties fall within the area controlled by another board.

(40) Communication with the Director, Division of Nursing, Bureau of Health Manpower Education, February 16, 1973.

(41) Wash. Senate Bill No. 2213 (enacted 1973).

(42) For example, see Cal. Bus. and Prof. Code sec. 1601 (Board of Dental Examiners), sec. 2100 (Board of Medical Examiners), and sec. 2703 (Board of Nurse Examiners) (West Supp. 1969).

(43) The seven-member Board of Nursing now has two public members. Cal. Senate Bill No. 1130 (enacted 1972).

(44) Cohen, *op. cit.,* pp. 81-82.

(45) *New Jersey Bateman Commission.*

(46) N. J. Stat., ch. 60, sec. 5 (March 1971).

(47) Derbyshire, R. C., "Better Licensure Laws for Better Patient Care," *Hospital Practice* 7:152, 161 (September 1972).

(48) *New Jersey Bateman Commission,* p. 35.

(49) Shimberg, *et al, op. cit.,* p. 230-231.

(50) *Ibid.*

(51) *Ibid.*, pp. 380-381.

(52) Pa. Senate Bills No. 1350 and 1486 (introduced 1972).

(53) *Supra,* note 46.

(54) Shimberg, *et al, op. cit.,* pp. 222-236.

(55) AMA, *Statement on Interstate Reciprocity* (Chicago, 1969).

(56) DHEW, *1971 Report on Licensure,* p. 45.

(57) *Supra,* note 40.

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(62) *Medical Licensure 1971,* p. 1606.

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(65) "Editorial, Basic Science Board Box Score: Six Down — Eighteen to Go." *Federation Bulletin,* 59:340 (September 1972).

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(86) *Ibid.,* p.752.

(87) "Medical Education in the United States," *Journal of the American Medical Association,* 222:961, 1019 (November 20, 1972). (Hereafter, *Medical Education in the U.S.).*

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(90) For a discussion of the relationship between the new "remedial" emphasis on continued competence in State licensing and the development of new methods of quality assessment, see Cohen, H. S., "State Licensing Boards and Quality Assurance: A New Approach to an Old Problem," in U.S. Department of Health, Education, and Welfare, *Quality Assurance of Medical Care—Monograph,* DHEW Publication No. (HSM) 73-7021 (Washington: U.S. Government Printing Office, 1973), pp. 49-65.

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(96) *California:* nurses (Assembly Bill No. 1497), optometrists (Assembly Bill No. 1576) *Florida:* osteopathic physicians (House Bill No. 3258); *Hawaii:* optometrists (Senate Bill No. 1612-72); *Kentucky:* podiatrists (House Bill No. 261); *Michigan:* podiatrists (House Bill No. 5461); *New Jersey:* pharmacists (Senate Bill No. 640); *Oklahoma:* chiropracters (House Bill No. 1625); *South Carolina:* optometrists (R. 1233, 5156) (all enacted 1972).

(97) *Supra,* note 96.

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99) Communication with Office of Medical Licensure, Frankfort, Kentucky, April 26, 1973.

00) Cal. Adm. Code, ch. 13, art. 15, sec. 1379.5 and 1379.8 (December 1972).These are the only situations requiring continuing education of physicians in California.

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02) *Darling v. Charleston Community Memorial Hospital.* 211 N.E. 2d 253 (Ill. 1965); *cert. den.* 383 U.S. 946 (1966).

03) Southwick, A. F., "Hospital Licensure," *Hospitals,* 44:49 (September 1, 1970).

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05) As of April 1973, 11 such organizations are funded. These are located at: (1) Stockton, California; (2) Sacramento, California; (3) Honolulu, Hawaii; (4) Portland, Oregon; (5) Salt Lake City, Utah; (6) Albuquerque, New Mexico; (7) West Des Moines, Iowa; (8) Jackson, Mississippi; (9) Atlanta, Georgia; (10) Charlottesville, Virginia; and (11) Waterville, Maine. In the period since April 1973, additional organizations have been funded.

06) The American Nurses' Association has expressed opposition to institutional licensure in a recent "Resolution on Institutional Licensure," ANA Convention, Detroit, Michigan, April 30 – May 5, 1972. The American Medical Association would include dependent practitioners except nurses under a system of institutional licensure, but not independent practitioners, such as physicians. AMA, *Licensure of Health Occupations, supra,* note 5, at p. 4. See also AMA House of Delegates resolution on "Institutional Licensure in Relation to Physicians and Nurses," June 26-28, 1973. A special committee study by the American Hospital Association recommended that the present system of licensure of health personnel be phased out and that Health Care Corporations be made responsible for the competence of all employees. AHA, *AMERIPLAN,* (Chicago, 1970) p. 25. Subsequently, the

official position adopted deleted this section and recommended that "alternatives to existing licensure provisions should be adopted if they provide for improved delivery of health care services."AHA, *Policy Statement on Provision of Health Services* (Chicago, 1971) p. 9. For a discussion of these positions, see Miike, L. H., "Institutional Licensure: An Experimental Model, Not a Solution," *Medical Care* (to be published in 1974).

(107) *Supra,* note 83.

(108) *Supra,* note 82.

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(122) "Keep Abreast, Doctors Told," *The Sunday Star and Daily News,* (Washington, D.C., October 1, 1972), p. 2.

(123) Ky. Senate Bill No. 244. *Supra,* note 98, at sec. 9.

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(128) *Medical Licensure* 1971, p. 1607.

(129) Rivera, E. S., Sifontes, J. E., "Post Graduate Medicine in Puerto Rico (A Refresher Course)," *Bol. Assoc. Med. P. Rico,* 64:211 (August 1972).

(130) Approved April 23, 1973.